ORGANIZATION FOR HEALTH CARE SERVICES

A STUDY CONDUCTED BY THE

OFFICE OF ORGANIZATIONAL APPRAISAL

(OP-09E)

31 JANAURY 1978

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PART 1

INTRODUCTION

As a result of the recent attention focused on the critical problems in military health care services, the Vice Chief of Naval Operations has expressed concern that the magnitude of the problems specifically related to the Navy may not have been fully outlined to the CNO. In consonance with a SECNAV-directed study of the organization and management of the headquarters of the Bureau of Medicine and Surgery and a CNO-directed review of the adequacy of staffing and distribution of medical personnel throughout the Navy, the VCNO tasked the Office of Organizational Appraisal, OP-09E, to conduct a study and develop recommendations concerning the following points:

TASK I - Organizational Alignment for Health Care Services in OPNAV

TASK II - Increased Utilization of MSC, Navy Line or Civilian Administrators at Regional Medical Centers

TASK III - Posture of the Navy with Respect to Current OSD Initiatives

The tasking letter is included herein as Appendix A and Tasks I through III are discussed and developed in Parts 3 through 5 respectively of this study. The resultant summary of recommendations is contained in Part 2.

Many studies in the health care services area have been conducted; a compendium is included as Appendix B. These formed the basic data bank of this study. A study team was formed of representatives of the affected OPNAV codes. The study commenced on 1 November 1977. The target completion date was 16 December 1977. The membership, listed below, offered a mixture of one line officer, 2 Medical Corps officers and 3 Medical Service Corps officers:

Director	RADM Gerald E. Synhorst (Ret.)	OP-09E

Representatives

OP-01	LCDR James D. Smith (2300)	OP-100F3
OP-04	CDR Lawrence L. Biesiadny (2300)	OP-415
OP-05	CAPT Paul S. Daly (1310)	OP-597

OP-098	CAPT Roger G. Ireland (2100)	OP-098E
OP-099	CAPT Stanley J. Kreider (2100)	OP-099M
OP-09H	LT Dale A. Knee (2300)	OP-09H1

A plan of action and milestones (Appendix C) was proposed and approved at the first meeting. However, because of the considerable volume of literature, required research and desire to avoid redundancy with ongoing studies, a request for extention of the completion date to 31 January 1978 was approved on 2 December 1977 (Appendix D).

PART 2

SUMMARY OF RECOMMENDATIONS

I-1. CNO establish a new DMSO, OP-093, to be entitled the Office of the Surgeon General directed by the Surgeon General on a double hat basis with the Chief of the Bureau of Medicine and Surgery.

I-2. CNO (OP-090) revise the Department of the Navy Programming Manual and current POM procedures to reassign resource sponsorship for medical programs to the new OP-093.

I-3. Surgeon General, in coordination with OP-09B, arrange to have a mission and function statement for the proposed OP-093 promulgated in the OPNAV Organization Manual. Proposed mission and function statements are listed on pages 12 and 13 of this Study.

I-4. Surgeon General with assistance of OP-09B arrange to have requisite OPNAV and BUMED billets, ceiling points and personnel transferred to proposed new OP-093.

I-5. Surgeon General, as OP-093, arrange to have regular DMC appointments with the CNO/VCNO.

I-6. Surgeon General, as OP-093, make arrangements to schedule full-fledged semi-annual CEB presentations on the status of the Navy Health Care System.

I-7. VCNO terminate the OPNAV staff practice of developing medical mission requirements, accomplishing routine medical programming and formulating medical policy by ad hoc study teams. These efforts are really day to day staff functions.

II-1. The Chief, Bureau of Medicine and Surgery continue to assign only Medical Corps officers to command Navy Regional Medical Centers.

II-2. The Chief, Bureau of Medicine and Surgery accomplish any further non-physician substitutions within the Navy Regional Medical Center system utilizing primarily Medical Service Corps and Nurse Corps officers where such substitution in senior administrative billets is possible.

II-3. CNO recommend to the Secretary of the Navy that appropriate legislative action be requested and supported to amend Title 10 restrictions addressing flag representation in the Medical Service Corps. Request one Medical Service Corps flag billet. Compensation for this MSC flag billet should come from Medical Department assets.

II-4. The Chief, Bureau of Medicine and Surgery, in coordination with the Chief of Naval Personnel and the Chief of Naval Education and Training, establish formal career paths for some Medical Corps and Medical Service Corps officers which would include a formal training program in health care administration and/or hospital administration.

II-5. The Chief of Naval Personnel develop for approval by the CNO a time phased plan to enhance the Medical Service Corps retention program and remove any unnecessary road-blocks in the Medical Service Corps promotion policy.

III-1. The CNO/VCNO insure concerted Navy input, in the medical area, to the OSD reorganization studies taking place under the guidelines of the Presidential Reorganization Project. Two studies are involved, the Resources Study (Rice Study) and the Defense Department Headquarters Study (Ignatius Study). Particular accent should be placed upon Navy-Marine medical contingency and wartime requirements as well as peacetime training therefor.

III-2. The CNO support the Defense Health Council concept and the Navy's Surgeon General participation therein. Other mechanisms intended to centralize control over medical matters in OSD would probably have a more adverse affect on the Navy Secretary's and the CNO's ability to do medical contingency planning.

III-3. The VCNO:

a. Insure constant, active participation by the Surgeon General in deliberations of the Defense Health Council, which appears to be a key OSD entity for control of military health care.

b. Insure awareness of DHC deliberations through both post-meeting discussions with the Surgeon General as well as personal, bi-annual updates for the CNO (along with appropriate DCNOs and DMSOs).

c. Make both formal and informal representation to SECNAV that all DHC recommendations be staffed through the SECDEF/SECNAV command chain prior to any decisions.

III-4. The Surgeon General:

a. In cooperation with the other Surgeons General, insure the DHC places greater relative stress upon medical readiness and contingency requirements as separate (although related) from peacetime care of the beneficial population.

b. Insure that his staff is organized to support him rapidly and thoroughly in participations of the DHC, especially in the planning and programming areas.

c. Suggest the DHC and OSD(HA) refrain from encouraging or sponsoring any further studies until a careful review is made of the multitudinous health care studies by OSD and the individual services during the past decade; determine what has been done, what should still be done, and what is presently impossible.

d. As a member of the OPNAV staff, work closely with OP-01/CHNAVPERS and CMC regarding those matters taken up by the Defense Health Council which affect retention, recruiting and morale of uniformed personnel in the Navy Department.

III-5. CHINFO, in view of the strong interest by personnel in the Navy and Marine Corps about medical care for themselves and their dependents, mount a more aggressive public relations campaign to explain the "whys" and "wherefores" of present medical-dental care. Particularly the complex CHAMPUS area should be stressed.

PART 3

TASK I

ORGANIZATIONAL PLACEMENT OF MEDICAL FUNCTIONS IN OPNAV

DISCUSSION. SECNAV/OPNAV staff must be the sole path between any second echelon command and higher authority; must actively manage and direct the planning and programming process; must have the lead in defending the budget in the OSD/OMB arena and before Congress; must have the ability to independently manage, direct and appraise the efforts and performance of the second echelon commands; and must have the ability to formulate department-wide Navy policy. The OPNAV staff must also have the ability to support the CNO in his role as member of the Joint Chiefs of Staff. In fact, in the case of medical functions the Chief, Bureau of Medicine and Surgery (Surgeon General) is carrying out most of these functions. This is because the OPNAV organization is not well equipped with respect to medical program functions. The only office within OPNAV with any central responsibility for medical functions is a small office attached to the Office of the Vice Chief of Naval Operations entitled Special Assistant for Medical Matters (OP-09H). This office is staffed by two officers on collateral duty, a Rear Admiral and a Lieutenant, both from BUMED. The remainder of the OPNAV medical functions and staff are scattered among various OPs including OP-01, OP-04, OP-05, OP-098, OP-099 and OP-09F. Most of these functions are performed by officers on collateral duty. In fact, there are 16 positions located in OPNAV occupied by medical department personnel; only four of these positions, however, are filled on a full-time basis by three medical department officers and a civilian employee. The remaining 12 officer billets are filled on a part-time basis by 10 medical department officers. In some cases one individual is assigned to more than one ADDU position. The role of these medical department personnel is primarily to provide technical assistance and advice on medical matters. The following positions have been identified:

OP-09 VICE CHIEF OF NAVAL OPERATIONS

*09H-Special Assistant for Medical Matters RDML ALMON WILSON, 2100
*09H1-Assistant LT DALE KNEE, 2300

OP-09F CNO SAFETY COORDINATOR

*09F7-Assistant Coordinator for Environmental Safety CAPT GEORGE LAWTON, 2100

OP-09R OFFICE OF NAVAL ~~RESEARCH~~ RESERVE

*09RH-Assistant for Medical Programs [illegible]
*09RE-Assistant for Dental Programs [illegible]

OP-96 SYSTEMS ANALYSIS DIVISION

*964D3-Medical Analyst LT. DALE KNEE, 2300

OP-098 OFFICE OF RESEARCH, DEVELOPMENT, TEST AND EVALUATIONS

098E-Assistant for Medical/Allied Sciences [illegible]

OP-992 PLANS AND POLICY DIVISION (NAVAL EDUCATION & TRAINING)

*992C3-Assistant for Medical [illegible]

OP-10 MANPOWER PLANNING AND PROGRAMMING DIVISION

100F3-Medical/Marine LCDR JAMES SMITH, 2300

OP-04 DCNO (LOGISTICS)

*04H-Medical Advisor CAPT BARCLAY SILLIMAN, 2300

OP-41 MATERIAL DIVISION

415-Head, Health Affairs and Programs Branch LCDR [illegible] RESIDENT, 2300

OP-45 ENVIRONMENTAL/PROTECTION, OCCUPATIONAL SAFETY AND HEALTH DIVISION

#454-Head, Occupational Safety and Health Branch [illegible]

OP-05 DCNO (AIR WARFARE)

*05F1-Assistant Safety/Aero Medical Coordinator CAPT JIM WENGER, 2300

OP-50 AVIATION PLANS AND REQUIREMENTS DIVISION

*506H1-Aviation Medical Survival Equipment CAPT MIKE CONLEY, 2300

OP-59 AVIATION MANPOWER AND TRAINING DIVISION

*59F-Assistant for Flight Physiology Training CAPT WENGER
*59G-Human Factors Engineering CDR RICHARD GIBSON, 2300

" OPNAV — 6.3/6.4/6.5 Programs
Hidden $ in Med R&D ([redacted])

	$ MIL Budget - FY 79	FY 80
63701N - Human Factors Eng. Development		
Funds to NAMRL	0.300	0.541
63713N - Ocean Engineering Technology Development		
M0019 - Deep Submergence Biomed	6.100	7.100
NMRDC	6.3 Σ = 6.400	7.641
64765N - Other Marine Corps Dev. (Eng)		
C0083 - Marine Corps Medical System	[redacted] = 0.700	0.700
	6.4 Σ = 0.700	0.700
65152N - Studies/Analysis Support, Navy		
M0106 - Nav Med Sup Cap	0.120	0.120
NMRDC		
65856N - Strategic & Technical Support		
M0100 - Biomedical Support - Sub Sup	0.400	0.500
NMRDC		
65861N - RDT&E Lab/Fac Mgmt Sup		
M0104 - Nav Med Mgt Sup	2.860	3.060
NMRDC		
65862N - RDT&E Inst/Mat Supp.		
M0105 - Navmed Inst/Mat Supp	2.040	2.580
NMRDC	6.5 Σ = 5.38	6.800
OVERALL TOTAL	= 12.48	15.141

*Billets filled on an Additional Duty Basis.
#Civilian.

The lack of an office to coordinate Navy medical program functions within OPNAV becomes more evident when one looks across this spectrum. Because of the way OPNAV programs and the Navy efforts are put together in the Planning, Programming and Budgeting System (PPBS) this organizational gap has weakened support for the medical effort. The Bureau of Medicine and Surgery through its own planning and programming effort is engaged at the second echelon of command in this effort which according to the aforementioned criteria for the SECNAV/OPNAV staff should in fact be performed in OPNAV. It is unlikely, however, that any second echelon command or bureau can play the PPBS game in OPNAV with the same efficiency and effectiveness as an element of the OPNAV staff. Medically related program elements among the various OPNAV offices were found to be divided as follows:

P.E	Title	Total Program $ (October 77) (In Millions) FY 79	FY 80	Sponsor Mission	Sponsor Resource
58131	Care in Defense Facilities	.4	.4	04	04
58136	Other Medical Activities	.1	.1	04	04
		(9.6) ERROR	(9.4)		
63706	Medical Development (ADV) OTHER 6.3 (MED)	7.9 6.4 14.3	7.9 7.7 15.6	098	04
64771	Medical Development (ENG) OTHER 6.4 (MED) 6.5 PROGRAMS (MED)	.9 .7 5.4 7.0	1.2 0.7 6.8 8.7	098	04
*87716	Other Personnel Support (Care of the Dead)	2.2	2.4	01	01
86722	Armed Forces Health Professions Scholarship Program	18.2	18.4	099	04
86723	Other Health Acquisitions	4.6	2.4	099	04
86761	Education & Training. Health Care	55.7	56.2	099	04
87711	Care In Defense Facilities	833.0	1017.5	04	04

RAD. TOTAL MEDICAL 79 80 .3 24.3

P.E.	Title	Total Program $ (October 77) (In Millions) FY 79	FY 80	Sponsor Mission	Resource
87713	Care In Non-Defense Facilities	21.1	22.3	04	04
87714	Other Health Care	15.3	15.2	04	04
87795	Base Communications, Health	4.8	5.1	094	094
87798	Management Head quarters (Health Care)	13.3	13.6	04	04

*Care of the Dead is a subelement of P.E. 87716.

The above P.E.'s represent the bulk of the medical support program resources. However, it is known that Medical Department activities generate resource requirements in virtually all major programs. It has been estimated that as much as 25% of the total cost of medical resources are not specifically identified as such. Once established a newly organized OPNAV medical element should identify and assume responsibility for additional resources.

Appendix E includes a detailed description of these Program Elements.

A number of organizational alternatives were examined to correct the apparent organizational flaw in OPNAV with respect to medical program functions. Several involved doublehatting. Before proceeding further, a few words on that subject. Normally because of the nature of OPNAV staff relationships with second echelon commands, the OPNAV staff should be capable of independently planning, programming and evaluating. Therefore, double hats which involve OPNAV and any second echelon command are not considered to be particularly desirable. When such staffing occurs, the CNO will lack a real staff capability to objectively review and evaluate the second echelon command involved. In the case of BUMED with respect to flag billets, if the Surgeon General were double-hatted as a separate DMSO, possibly OP-093, such arrangements would be similar to the OP-01/ BUPERS tie up. However, if a two star flag officer were doublehatted from BUMED to any organizational placement within OPNAV (i.e. either under a DCNO or DMSO to direct a medical division or as director of an independent staff office under the CNO and VCNO) the result would be less desirable because it is doubtful that an officer placed in such a position could independently and

effectively evaluate the performance of his primary superior. Double hats among OPNAV codes for officer billets of lesser rank are not considered to be desirable either, but they are less undesirable than double hats involving a second echelon command. Some internal OPNAV doublehatting may in fact be necessary due to shortages of officers and billets.

The following organizational alternatives were examined: (1) to establish a DMSO, OP-093, entitled the Surgeon General doublehatted as Chief, Bureau of Medicine and Surgery; (2) to establish an independent office with a full time two star medical flag officer under the VCNO; to establish a medical division headed by a full-time two star medical flag officer under either (3) OP-01 or (4) OP-04. Because of the aforementioned objections to doublehatting the only alternative with a flag officer doublehatted that was examined was the one in which the Surgeon General would be doublehatted as a DMSO. To go one step further and separate the Surgeon General from command of the Bureau of Medicine and Surgery and to assign him solely to a role on the OPNAV staff, while simultaneously assigning a two star medical admiral to command the Bureau or some other form of health services command, would be similar to the organizational arrangements of the Army and Air Force.

Status quo as an alternative was also considered but rejected because it does not correct the basic problem concerning the lack of central coordination of medical programs in OPNAV. Alternative (1) involved the doublehatting of the Chief, Bureau of Medicine and Surgery as a DMSO entitled the Surgeon General, OP-093. This would unquestionably result in improved coordination within OPNAV and would give the Surgeon General in his newly established staff role improved access to the VCNO and the CNO. It would also have the advantage of being similar to the OP-01/BUPERS arrangement which has been in existence for years and is well understood. Likewise, except for the double hat facet it would correspond to the Army and Air Force set-ups. If this alternative were adopted and the title "Surgeon General" were reserved for the DMSO role, it could serve as a useful intermediate organizational solution with the ultimate being the complete separation of the Surgeon General and the Chief, Bureau of Medicine and Surgery titles and responsibilities. It does, however, suffer the disadvantage of doublehatting between OPNAV and a second echelon command.

Alternative (2) involving the establishment of a strengthened OP-09H under a full-time medical two star flag officer would also improve coordination. It would not

suffer the disadvantage of the OPNAV/second echelon double-hatting. Like all the alternatives considered it would require some additional staffing and some transfer of functions and staffing from BUMED to implement. It would, as is the case of most small independent offices, not have the visibility and direct access to the CNO and the VCNO usually accorded DCNO/DMSOs. Because of this, generally a function in OPNAV receives more attention from the VCNO and the CNO if it is under the aegis of one of the DCNO/DMSOs. Another major disadvantage of this arrangement is that there would be an interservice imbalance i.e. the Army and Air Force would both have their Surgeons General in a role in which the Navy would have an officer of less stature. This is a significant problem. The OSD staff deals with the three Surgeons General frequently, so does Congress on occasion. In the Navy's case the Surgeon General is merely another term for CHBUMED, a second echelon command. Hence, the SECNAV/OPNAV staff is being bypassed routinely. Putting a Rear Admiral Medical Corps on the OPNAV staff as primary duty would almost certainly not stop this practice.

Alternatives (3) and (4) involved consideration of the establishment of a medical division under a full time two star Medical Corps flag officer under either OP-01 or OP-04. The choices were narrowed to these two DCNOs because they appear to be most logical choices among DCNOs or DMSOs. There are strong arguments to be made in favor of either of those DCNOs based upon current thinking and tradition. By a process of elimination the other DCNOs and DMSOs were removed from consideration. For example, the medical program functions should not be tied to any one of the three platform oriented DCNOs i.e. OP-02, OP-03 and OP-05. Likewise by the nature of their primary missions in C^3 and ASW, OP-094 and OP-095 were not logical choices. Medical functions encompass a considerably broader scope than either RDT&E or training and education, thus OP-098 and OP-099 were not considered appropriate. OP-090 and OP-06 by their nature were also inappropriate; the former because of the OP-090 "honest broker" role among all OPNAV programs, and the latter simply because the nature of the major OP-06 function is almost totally foreign to the medical program effort. In the case of OP-01 and OP-04, however, a strong case can be made to tie a medical division to either.

Philosophically, health care is most closely related to the functional field relating to human resources. It is a "people oriented" effort. In this respect, therefore, it fits in closely with OP-01, particularly an OP-01 which would be restructured to include personnel administration policy as well as manpower policy. Also, in the recent past, there has been a tie between Navy health care efforts

and Navy personnel and manpower efforts at the ASN level. Thus, before the recent combination of ASN(I&L) and ASN(M&RA) functions, medical functions were represented at the Navy secretariat level by the ASN(M&RA). The above suggests placing an OPNAV medical division under OP-01.

There is, however, at least as strong a case to place the OPNAV medical division under OP-04. As noted in the exhibition of responsibilities for resource and mission sponsorship, nearly all resource sponsor responsibilities are currently assigned to OP-04. Thus, there would be less perturbation in the OPNAV sponsorship arena if the medical division were assigned to OP-04. There are also strong traditional reasons in favor of OP-04. NWP-12 in describing the typical Navy Staff calls for medical and dental functions to be under either Administration (N1) or Logistics (N4). (Appendix F) Chapter 6 of NWP-11, which deals with the nature of naval logistics, cites medical and dental services functions as activities of Navy logistics (Appendix G). Within the Joint Staff, J4 is the lead office for medical and dental matters. Recent changes in the ASD and ASN structures now place medical and dental functions in OSD and in the Navy secretariat under the same ASD and ASN respectively who are concerned with logistics.

A central medical element in OPNAV should be concerned with a variety of functions but primarily with functions such as policy formulation, coordination of OPNAV staff efforts in the health care field, acting as focal point in dealings with higher authority, being the primary resource sponsor for health care efforts, and appraising health care efforts throughout the Navy. A possible mission and function statement for such an OPNAV element could be as follows:

Mission: To provide, within OPNAV, centralized coordinated, policy formulation, guidance and direction, and professional and technical advice on all health care related programs. To ensure adequate medical resources and trained personnel are available to meet Navy/Marine Corps contingency plans. To ensure that Navy's responsibility to safeguard and protect the health of Navy/Marine Corps personnel, their dependents and other personnel as authorized by law is met.

Functions:

1. Develop Navy health care program policy and guidance and provide professional and technical advice on matters pertaining to naval health care.

2. As a resource sponsor for designated health care programs, coordinate as necessary with other sponsors in regard to the Navy/Marine Corps health care requirements.

3. Review and appraise the capability of the Navy medical department to respond to contingencies.

4. Review and appraise the performance of the Navy medical department in safeguarding and protecting the health of authorized beneficiaries.

5. Act as central point of contact for naval health care matters involving coordination within OPNAV.

6. Provide backup for meetings on health care matters.

7. Assist DCNO (Manpower) in the preparation of plans, policies, and studies pertaining to Navy medical manpower requirements.

8. Assist DCNO (Logistics) in the preparation of plans, policies and studies pertaining to medical logistical support including the Prepositioned War Reserve Material Program.

9. Assist OPNAV mission and resource sponsors in programs that have health care impacts.

The staffing of the proposed OPNAV medical element should be austere. After a period of operation for approximate one year, the staff should be reevaluated and if additional resources are required they should be added at that time. Initially the source of billets should be several of the billets currently assigned to OPNAV programs plus additional billets from BUMED to properly realign the Navy PPBS efforts. In some instances the officers in OPNAV who would be reassigned to the OPNAV medical element would still have to be assigned for collateral duty to another OPNAV division. In no instance, however, should OPNAV doublehatting combine the Resource Sponsor and OP-090 because of the adversary relationship which should exist between these organizations. A sample staffing plan could be as follows:

2100	C/D	Surgeon General or Director of Medical Programs
2300	G/H	Executive Assistant
GS-7		Secretary
2300	G	Hd, Planning, Programming & Budgeting Branch
2300	I	Assistant for Planning
2300	I	Assistant for Programming
*2300	I	Assistant for Logistics & Medical Support
2300	I	Assistant for SECNAV, DoD and Legislative Affairs
*2300	I	Assistant for Personnel

	GS-6	Secretary
	GS-5	Secretary
**2100	G	Hd, Professional Branch
**2100	G/H	Assistant for Operational Medicine
**2100	G/H	Assistant for Training
*2100	G/H	Assistant for Research and Development
	GS-6	Secretary
	HM-1	Clerical Assistant

*Doublehatted to another billet within OPNAV.

**At least one of the (2100) officers assigned to this branch should be a flight surgeon.

The Surgeon General is responsible, under the Chief of Naval Operations (CNO), for the Navy Health Care System. This responsibility includes keeping the CNO apprised of matters having a significant impact upon the system on a continuing basis. The Surgeon General now has access to CNO/VCNO through intermittent attendance at the CNO's Daily Morning Conference (DMC). The current high visibility being experienced by the health care system, the increasing number of external influences being exerted upon it, and the dynamic nature of the system itself dictate the necessity for regular discussions with CNO/VCNO. The most obvious and convenient forum for such discussions is the DMC. As a DMSO, as proposed, such regular DMC appointments would be in order.

To assist the CNO in fulfilling his responsibilities it is imperative that the OPNAV medical organizational element keep him advised of significant problems, on-going initiatives to overcome them and available alternative solutions. This action should be taken on a regular and formal basis in an atmosphere which would allow a critical analysis of alternatives and decisions regarding their implementation. The vehicle for such presentation exists as the CNO Executive Board (CEB).

RECOMMENDATIONS:

1. CNO establish a new DMSO, OP-093, to be entitled the Office of the Surgeon General directed by the Surgeon General on a double hat basis with the Chief of the Bureau of Medicine and Surgery.

2. CNO (OP-090) revise the Department of the Navy Programming Manual and current POM procedures to reassign resource sponsorship for medical programs to the new OP-093.

3 . Surgeon General, in coordination with OP-09B, arrange to have a mission and function statement for the proposed OP-093 promulgated in the OPNAV Organization Manual. Proposed mission and function statements are listed on pages 12 and 13 of this Study.

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6. Surgeon General, as OP-093, make arrangements to schedule full-fledged semi-annual CEB presentations on the status of the Navy Health Care System.

7. VCNO terminate the OPNAV staff practice of developing medical mission requirements, accomplishing routine medical programming and formulating medical policy by ad hoc study teams. These efforts are really day to day staff functions.

PART 4

TASK II

INCREASED UTILIZATION OF MSC, NAVY LINE OR CIVILIAN ADMINISTRATORS AT REGIONAL MEDICAL CENTERS

DISCUSSION. Traditionally within the three military services, as well as the civilian health care systems, the physician has been inherently considered the chief "administrator" of health care delivery. This view is changing as we enter an era of austere physician manpower levels which are strained to adequately meet the increasing health service demands. Increased federal pressures for optimizing health personnel resources, while minimizing health costs, have tended to increase the shift from physician to non-physician administration. A 1975 report by the National Center for Health Statistics[1] (in coordination with major American health systems) revealed that only 12% of the U.S. health facilities have physicians as the "chief administrator," and that this percentage will continue to diminish over the next 20 years. Therefore, implicit in any review of increased utilization of non-physician administrators within the regional medical center system must be an assessment of the resultant increase of physicians in direct patient care positions. Also, another measure of effectiveness that must be considered in any scheme of substitution is the quality of administration and management of the health care system. If not enhanced, it must be at least as effective as the present structure and consistent with the mission and functions of Navy medicine.

A review of the past and present structuring of the Navy CONUS Health Care System was conducted with emphasis placed on the current senior administrative billet distribution within the regional medical center system. Organizations not incorporated in the regional concept (staff, R&D and headquarters levels) were not included nor was billet validation analysis attempted. This approach yielded a step-history study, a snapshot view of the current regional structure and several pertinent facts:

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[1] Management of Hospitals, Schultz & Johnson; p. 130.

o Presently 76 of the 144 billets in the regional system (52.8%) considered to be "Senior Administrative" are occupied by Medical Service Corps officers.

o The vast majority of administrative billets below those considered senior are non-physician i.e. MSC, Nurse Corps, Dental Corps and enlisted.

o Within the last four years the Navy has methodically increased the use of Medical Service Corps officers in previously designated Medical Corps administrative billets.

o The Navy system's transition to utilization of non-physicians in administrative billets closely parallels that of the civilian community.

o With the advent of the regional medical center concept, Medical Service Corps officers have been afforded major command opportunities in the form of hospitals within and under the auspices of these regions. They now command 7 of the 11 naval hospitals not designated regional medical centers.

o Only a limited potential exists for increased utilization of additional non-physician health care administrators at the senior administrative levels in Naval hospitals and regional medical centers.

The current senior administrative billet structure for Navy Regional Medical Centers, Hospitals and Branch Clinics is portrayed in Table I. For the purpose of this discussion the phrase "Senior Administrative" is limited to the following (billets are described in Appendix H):

1. For NRMCs and NHs:

   - o Commanding Officer (CO)
   - o Director, Clinical and Medical Services (DCMS)
   - o Director, Administrative Services (DAS)
   - o Regional Health Care Coordinator (RHC)

2. For Branch Clinics:

   - o Officer-in-Charge (OIC)
   - o Head Medical Department Representative (HDMEDDPT)

TABLE I

SENIOR ADMINISTRATIVE BILLETS IN THE NRMC STRUCTURE

NAVAL REGIONAL MEDICAL CENTERS (Total 26)

Position	Rank	Total Number	
Medical Corps (2100)			
CO	0-7	6	
CO	0-6	20	
DCMS	0-6	10	TOTAL - 41
DAS	-	0	
RHC	0-5/0-6	5	
Medical Service Corps (2300)			
CO	0-6	0	
DCMS	-	0	
DAS	0-5/0-6	26	TOTAL - 29
RHC	0-5/0-6	3	

NAVAL HOSPITALS (Total - 11)

Position	Rank	Total Number	
Medical Corps (2100)			
CO	0-6	4	
DAS	-	0	TOTAL - 4
Medical Service Corps (2300)			
CO	0-6	7	
DAS	0-5/0-6	11	TOTAL - 18

BRANCH CLINICS (Total - 54)

Position	Rank	Total Number	
Medical Corps (2100)			
OIC	0-5	4	
HDMEDDPT	0-3/0-6	19	TOTAL - 23
Medical Service Corps (2300)			
OIC	0-3/0-6	29	TOTAL - 29

GRAND TOTAL 76 Medical Service Corps and 68 Medical Corps = 144

As illustrated in Table I, only a few billets, mostly in the area of regional medical center command, remain available for consideration for substitution (all regional medical centers are under the command of Medical Corps officers). Since there are six Medical Corps flag billets included and the Directors of Clinical Medical Services (DCMS) must be physicians, it is obvious that even wholesale substitution in the few remaining administrative positions would not return a significant number of physicians to direct patient care positions. Such a wholesale substitution is, of course, infeasible because of its detrimental effect on morale, disruption of the normal professional chain of command and subsequent elimination of positions of progressive responsibility for Medical Corps officers acceding to higher command and flag rank. Most importantly, in order to fulfill one of the primary missions of navy medicine, there must remain the administrative capability and expertise to organize and deploy division medical units during any contingency mobilization. If an adequate number of positions remain physician-designated to keep the normal chain intact, a maximum of perhaps 15 billets can be considered for substitution, the majority of which are commands of Navy regional medical centers.

In addressing the command of Navy Regional Medical Centers, it must be kept in mind that these positions are the main linking pins of a system primarily designed for patient care directly to the Chief, Bureau of Medicine and Surgery. The Centers are also the hub of resident intern and physician training and house various boards and committees which report directly to the Commander and are instituted to resolve complex medical decisions. It is conceivable that if the Commanding Officer of a Regional Medical Center were not a physician some medically based decisions eminating as low as a branch clinic would not have the benefit of physician oversight until the matter reached the Chief of the Bureau of Medicine and Surgery. It must be concluded that the positions of Commanding Officer of Navy Regional Medical Centers should be held by members of the Medical Corps.

An analysis of the possible utilization of Navy line officers or civilian administrators in either health care or hospital administrative positions revealed that, although theoretically feasible, actual implementation of such a step would create more disadvantages than advantages. Either approach would adversely affect recruitment, career motivation and retention of those in the Medical Corps and Medical Service Corps who aspire to command.

It would be unwise to consider a generalist, such as a Navy line officer, qualified to administrate such a highly technical and specialized field. Indeed, a technical specialty would have to be created under the Operational Technical Managerial System (OTMS) (one shore tour of PG training and one of apprenticeship prior to assuming responsibility in the field) to assure the high quality end product desired. Beside detracting from the line officer's warfare specialty, it would be inefficient to create this technical specialty for only a few billets in a limited field not even remotely related to any of the warfare specialties. In fact, it is a counterproductive method of accomplishing one of the specific tasks of the Medical Service Corps.

Civilian substitution would decrease the mobilization level of Navy medicine in time of emergency. Civilians could not be used to organize, train, administer and deploy with Contingency or Reserve elements as Medical Corps and Medical Service Corps officers do. Additionally, no real comparison can be drawn between a strictly administrative organization as exists in civilian hospitals and the chain of command which must be the bulwark of a military hospital or medical center. Civilian administrators could be utilized only in positions not functionally included in the military command structure. The majority of these type positions are not in the "Senior Administrative" category, are now being adequately filled by non-physicians, and therefore would not release any Medical Corps officers to direct patient care if occupied by civilians. In the "Senior Administrative" category consideration has been given to the use of civilian physicians as Directors of Clinical and Medical Services, but the DCMS (as described in Appendix H) is regarded as a training billet for potential CO's, the second in command in the military structure and the acting commanding officer in his absence. It would create an extremely difficult organ-ization problem if such a position were occupied by a civilian.

Another source, not addressed in the tasking letter but considered to be well qualified, is the Navy Nurse Corps. Closely allied to the technical specialties involved and possessing a wealth of knowledge and experience in the overall administrative structure of health care services, this untapped source could provide (in conjunction with the Medical Service Corps) a more efficient solution to the problem than either Navy line or civilian administrators.

It is concluded that the increased utilization of MSC officers, with their background and proven abilities, and the possible supplementary use of Nurse Corps officers, offers the most attractive alternative for increasing the number of physicians in direct patient care and for maintaining the quality of administration.

During review and examination of the administrative and command billet structure and accession to these positions, a noticeable absence of clearly publicized career patterns and formal training requirements to assure quality health care administration or hospital administration for both the Medical Corps and the Medical Service Corps was detected. Aside from generating the possibility of placing marginally qualified personnel in administrative and decision-making positions, this situation creates uncertainty in the minds of younger officers aspiring to command and detracts from the efficient functioning of a personnel system which must provide a well qualified manpower base. It appears possible for officers of both the Medical Corps and Medical Service Corps to reach the rank of Captain (and flag rank in the case of the Medical Corps) with no business and administration training or experience at all. Not every officer should get the training and experience but certainly some careers should be purposely tailored that way. A well planned training and career program with major command and flag rank as attainable goals would substantially enhance the overall administration and management of the entire Navy health care system.

Another issue to be addressed here is the retention rate of MSC officers. There continues to be a shortfall in MSC Captains. This condition is created by the early retirement of many well qualified officers who opt for lucrative civilian counterpart positions and the inability to promote the necessary numbers due to the promotion zones being tied to the line officer community. As of 1 November 1977, the below manpower imbalance existed for the grade of 0-6:

Authorized Billets	On Board	% Manned
90	44	48.4%

If we are to utilize the Medical Service Corps in more responsible positions, we must fill these authorized billets. This staffing situation is not expected to improve over the next five-year period due to small promotion zones and limited percentage selection. Since promotion zones are

tied to line requirements, a change in the percentage selection appears the only feasible alternative available to correct the imbalance. CHBUMED has requested of CHNAVPERS the promotion percentage be modified from 60% to 90% for FY 79 and FY 81. If approved, the effect would be to increase the 0-6 community from an end strength of 71 to 83 in FY 82. Although the MSC imbalance is most apparent at the 0-6 level, there exists a growing imbalance at the 0-5 and 0-4 levels which will create future imbalance. The current percentage promotion to 0-5 is 70% and to 0-4 is 85%.

The Medical Service Corps remains the only officer community without flag representation. Title 10, USC sets the limit for promotion opportunity for MSCs at the 0-6 level. This situation is a demoralizing factor for MSC officers and is considered to be one of the factors leading to the early retirement of many MSC officers at the 0-5 and 0-6 levels. Currently no effective action is being pursued to correct this inequitable situation. Enactment of the pending Defense Officer Personnel Management legislation could remove the legal roadblock to this problem. However, near-term passage seems remote.

In summation, there exists only a limited potential for increased utilization of non-physician health care administrators at the senior administrative levels in Navy hospitals and regional medical centers. Utilization of the Medical Service Corps, supplemented by the Nurse Corps, to effect this substitution process is the most attractive alternative. The substitution process should proceed at a methodical pace as MC and MSC command career patterns are developed and a solution to the senior MSC officer retention problem is effected.

RECOMMENDATIONS:

1. The Chief, Bureau of Medicine and Surgery continue to assign only Medical Corps officers to command Navy Regional Medical Centers.

2. The Chief, Bureau of Medicine and Surgery accomplish any further non-physician substitutions within the Navy Regional Medical Center system utilizing primarily Medical Service Corps and Nurse Corps officers where such substitution in senior administrative billets is possible.

3. CNO recommend to the Secretary of the Navy that appropriate legislative action be requested and supported to amend Title 10 restrictions addressing flag representation

in the Medical Service Corps. Request one Medical Service Corps flag billet. Compensation for this MSC flag billet should come from Medical Department assets.

4. The Chief, Bureau of Medicine and Surgery, in coordination with the Chief of Naval Personnel and the Chief of Naval Education and Training, establish formal career paths for some Medical Corps and Medical Service Corps officers which would include a formal training program in health care administration and/or hospital administration.

5. The Chief of Naval Personnel develop for approval by the CNO a time-phased plan to enhance the Medical Service Corps retention program and remove any unnecessary road-blocks in the Medical Service Corps promotion policy.

PART 5

TASK III

POSTURE OF THE NAVY WITH RESPECT TO CURRENT OSD INITIATIVES

The Office of the Secretary of Defense is today the most potent single force affecting the Navy's portion of the Military Health Care System (MHCS). There are over a dozen important OSD initiatives to which individual services must react. Indeed, Navy medicine has gone from an active to a reactive mode within the past few years.

The initial trigger for almost all present OSD health care initiatives was the December 1975 Report of the Military Health Care Study, produced by the Department of Defense, Department of Health, Education, and Welfare, and Office of Management and Budget. The key recommendation (initiative #2) therein was:

> "A central entity within DoD serving as a coordinating mechanism for planning and allocating resources should be established to oversee health care delivery in CONUS." (emphasis added)

On 28 December 1976 the Secretary of Defense established a DoD Health Council to meet the objectives of the study and to advise him concerning overall health matters (Appendix I). This comprised:

> ASD (Health Affairs) -- Chairman
> Surgeon General of the Army
> Surgeon General of the Navy
> Surgeon General of the Air Force
> A representative from JCS
> A representative from the Uniformed Services University of the Health Sciences

It is important to note that the Surgeons General of Army and Air Force are on the staffs of their respective Chiefs of Staff (echelon 1); the Navy Surgeon General is Chief of

the Bureau of Medicine and Surgery (echelon 2). This relationship in effect has the Navy echelon 2 commander bypassing both of his superiors, CNO and SECNAV, in dealing with the OSD staff and the Congress.

Even before its formal establishment the DHC was a matter of Navy concern. On 15 December 1976 the Assistant Secretary of the Navy (M&RA) wrote to ASD(HA) (Appendix J):

> "The proposed charter and statement of objectives contain specific references to planning, programming, evaluation, and the exercise of oversight ... which have the potential to create .... undesirable conflict."

Such concern was justified. Title 10 USC vests departmental readiness for war in the SECNAV and CNO. This specifically includes "procurement of naval stores and material" (section 5031), "supervision" (section 5081), and determination of "personnel and material requirements" (section 5082).

In his establishing memorandum, SECDEF directed that a report containing a recommendation for continuation of Defense Health Council (DHC) be submitted prior to 3 January 1978. This was done on 30 December 1977 by the outgoing ASD(HA), Dr. Smith. In his lengthy report (Appendix K) Dr. Smith proposed that the DHC be formally chartered by official directive. A decision on this is presently pending.

Despite its innocuous title, the Defense Health Council has probably been the most formative instrument in increasing OSD control of service medicine. The worthwhile concept of a Surgeons General group to coordinate interservice medicine has almost become a bureaucratic facade for OSD control. Major OSD initiatives in this area include:

Development of contingency and mobilization requirements
Uniform chart of accounts
Capitation budgeting
Marginal cost analysis
Equipment review policy

Contingency and mobilization requirements are being developed which will:

o Validate (or disprove) the recommendation of the 1975 Military Health Care Study insofar as the basic element of size and composition of the military medical force is concerned.

o Establish a clear-cut method of assessing the risks (in terms of mortality, morbidity, and return to duty) associated with alternate levels of resource allocation.

o Generate a better basis of providing the SECDEF advice as to probable effects of proposed planning and programming decisions. Sub-objectives include development of new techniques for identifying and analyzing the major variables affecting medical contingency and mobilization planning, and the encouragement of fuller interservice cooperative medical planning.

It is important to note, however, that OSD attention is directed mainly toward the cost-effective peacetime health care -- as indicated by most of the OSD initiatives which follow.

The Health Affairs National Security Planning Study contains a series of sub-studies. To date, DIA has been commissioned to review wartime injury and disease rates. This review is to be completed by March 1978. Also, physician's wartime productivity profiles are being developed and the problems associated with relying on selective service during wartime are being addressed. This entire study is critical but is not progressing rapidly so far.

The Office of the Assistant Secretary of Defense (Health Affairs) -- in conjunction with OSD(COMP) -- is developing uniform cost accounting systems which are consistent across all military facilities. The first step is to develop a Uniform Chart of Accounts. The purpose of this is to provide a common standard of measurement and communication, both inter and intra service, through the use of uniform accounting principles, standardized terminology, common classification of costs by work center, statistical definitions, and cost finding methodology. It is anticipated that this Chart of Accounts and subsequent reporting systems will be superimposed upon already existing service programming systems. Inevitably, this will necessitate the allocation of additional resources to the accounting function.

A capitation budgeting methodology is currently under development by a consultant firm under contract to ASD(HA). A one-year test of this budget approach is planned for DoD Region #1 (Bremerton) and Region #9 (Pensacola) during FY 1978. This methodology only addresses the peacetime CONUS health care delivery function. Current budget processes will continue in use for all other health care functions. Thus, the Navy health care function will be subjected to a diverse budgetary approach. Further, this

initiative could transfer resource control and thus operational control of Navy resources to an-as-yet undefined central coordinator for all military services in those regions affected by the FY 78 test.

Marginal cost techniques are under study by a separate ASD(HA) working group. The purpose is to determine the allocation of patients between CHAMPUS and military medical facilities through this form of economic analysis.

Equipment review at the OSD level has been instituted by a recent DoD instruction for all medical/dental equipment items with a unit cost greater than $100,000 (Appendix L). The purpose of this review is to eliminate duplication of equipment items among tri-service hospitals. Such review decisions, external direction, and imposed constraints will fragment and overrule the Navy's equipment procurement actions decision processes. It will inhibit Navy's procurement of equipment needed for training medical personnel for war. It will prevent internal Navy programming trade-offs.

There are additional and important ongoing OSD(HA) actions in which the Defense Health Council is involved. These are:

o Demand Model - To develop a tool for military health planners to estimate the total demand for health care services within any area (or a system for use in integrated resource planning and programming). The initial collection of population and utilization data has been completed. The model is completed. Plans are to update it regularly and make it available for use by the three services.

o Validate Teaching Requirements - To review past and present planning policies and program requirements for graduate professional education (GPE); develop an understanding of the effects on future military departments force structures (by specialty) of changing the size of GPE programs. The analysis of effects on current peacetime force projections of changes to physician GPE levels has been completed. However, distribution of the report has not been accomplished. This working group has not met for some time although independent action has been pursued by ASD(HA). The analysis of effects on current peacetime force projections of changes to physician GPE levels has been completed, but distribution of the report has not been made.

o Underserved Area Criteria - To develop criteria by which to delineate medically/dentally underserved areas; to determine additional medical resource requirements relative to underserved area designation and beneficiary population;

and to permit periodic review and updating of criteria and designated areas. This work group has examined criteria for defining underserved areas developed by federal agencies other than DoD. It is anticipated that an attempt will be made to obtain HEW data as an initial step in determining underserved areas. The project has recently been stalled because of difficulty in getting data on physician distribution by specialty from the American Medical Association.

o Standard Data Reporting System - To provide the beginning of a common index of standard data elements and related features for use throughout the users served by the information system. This work group has a contract with the Systems Development Corporation for development of an information system to support the efforts of the other work groups. First results should appear in early 1978. Eventually this must be joined to the presently separate Tri-Service Medical Information System (TRIMIS). See page 32.

o Criteria for Delineating Regions - The Defense Health Council has approved the boundaries for this effort in coordination with current Service review; anticipate SECDEF approval in July.

o Utilization Review in the MHCS - To identify utilization control practices in civilian and military facilities; evaluate the modification and/or adoption of those practices not currently utilized by the Services; implement desirable and feasible UR program features; assess effects and impacts of adopted practices. Was scheduled for completion in December 1977 but not implemented. Role of group not yet clearly defined.

o Coordination of CHAMPUS/Direct Care System - To improve and coordinate the allocation of medical resources within a DoD regional structure. All major tasks completed. CHAMPUS and direct care workload and costs identified for FY 75. A comparative report has been published and is currently undergoing Service analysis.

The DHC was originally chartered to provide "coordination, standardization, and oversight." Yet it has obviously keyed decisions -- sometimes unilaterally by OSD(HA). It must be stressed that in the Navy Department this has the effect of the Surgeon General (Chief, BUMED) bypassing two senior echelons of command, the CNO and SECNAV. Deliberations of the DHC -- converted to ASD(HA) decisions -- have also bypassed the Navy's programming system. This in effect fences those resources which ASD(HA) has decided to devote

to each service. Such actions contradict the Navy and OSD PPBS system which is designed for careful consideration of intra-Service and inter-Service trade-offs.

Dr. Smith's report of 30 December 1977 also proposed a directive formally establishing an Armed Forces Regional Health Service System (AFRHSS). The Defense Health Council was to be the overseer of the AFRHSS. The proposed DoD Directive 6010 states:

> "The Armed Forces Regional Health Services System is to be the principal means of coordinating the organization and management of health care delivery on an integrated tri-service basis within specified geographic areas."

In actuality this would appreciably affect operational control of the Navy Health Care Delivery System. OSD initiatives in this area include both tri-service regionalization of CONUS facilities and external coordination of the CONUS health care facilities under the coordination control of a tri-service regional health care coordinator; nine large geographic regions would cover all CONUS health care facilities. It is anticipated that the Navy Medical Department would be assigned coordination control over two such regions centered in San Diego, California and Portsmouth, Virginia. The remaining seven CONUS regions would be divided between Army and Air Force. Thus, the majority of CONUS Navy health care facilities would be under the coordination control of Army or Air Force regional health care coordinators. The entire CONUS hospital system would function in a "coordinated" manner as opposed to a service-oriented type system. The tri-service emphasis is directed mainly toward CONUS patient care facilities (hospitals and clinics).

Navy concerns are that "coordination" could -- probably would -- evolve into OSD directive authority with resulting fragmentation of the Navy health care system and deemphasis of health care functions important to the Navy and Marine Corps. Official objections to the Armed Forces Regional Health Services System were succinctly stated (Appendix M) by ASN(MRA&L):

> "The proposed DoD Directive would give broad powers to ASD(HA) as Chairman of the Defense Health Council which could undermine the functions of the Service Secretaries and Service Chiefs in the

> operation of the Service Health Systems. Further, the Directive could in the future be interpreted as authority for ASD(HA), as the DHC Chairman, to bypass the Surgeon's [sic] General and interface directly with field activities."

The Navy should have no objection to those initiatives which relate to better identification of costs and closer cooperation among the military medical departments. However -- and this affects the Navy-Marine raison d'etre -- there is a major area of concern involving the potential of curtailing Navy control over health care operations and resources: fleet readiness and preparations for war. Contingency response capability is vital. Navy medical/dental contingency response relies upon resources drawn from CONUS facilities, and contingency readiness requires rapidly deployable assets. The initial response draws upon identified and trained teams; surgical teams and FMF augmentation teams are examples. However, full response relies upon the rapid deployment of large numbers of personnel from CONUS hospitals which serve as a trained manpower pool. External redirection and redistribution of assets to meet peacetime CONUS needs will degrade medical/dental capabilities to respond to Navy and Marine Corps contingency needs.

Another important although long-term matter is the presidentially-directed examination of service resource management and common resource support. This will address overlapping areas in "supply, maintenance, training, health care delivery, base operations and the like" as well as potential consolidations. Specifically the Presidential Memorandum[1] directed the Secretary of Defense to prepare a study plan to include:

> "What changes in Department of Defense organization for resource management will provide increased control, accountability, efficiency, economy, and readiness."

Military medicine will be carefully scrutinized; the presidential charter mentioned "medical corps headquarters and direct health care facilities" and "changes in medical/health care delivery." This can profoundly affect Navy health care. An example listed under "Summary of Problems and Opportunities" attached to the Presidential Memorandum was:

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[1]President Carter's Memorandum for the Secretary of Defense dated 20 September 1977.

> "Each military department maintains a medical corps headquarters and direct health care facilities. Fifty percent of military hospitals are within 50 miles of another military hospital; there is little cross-service coordination. In the Washington, D.C. area, there are four military hospitals. The San Antonio, San Diego, and San Francisco areas each have two military hospitals."

Constraints noted in the memorandum as given are formidable:

> "Each military service in the defense structure will work to protect its base of support activities. The services' concerns will be that reorganization of functions will impair readiness. The support functions, with their facilities and manpower levels, are important to elected representatives and officials where these activities are located. Political pressures resulting from closing bases and consolidating functions will be intense. Any changes in medical/ health care delivery will arouse great concern and may meet resistance from retirees and dependents."

This "Rice Study" group is still in its formative stages. However, its power for change should not be underestimated. Any OSD-driven tendency to concentrate on peacetime cost-benefit trade-offs while minimizing contingency and wartime medical requirements could be dangerous.

It is possible that a similar on-going examination of the DoD organization may result in organization changes affecting service medical care. The "Ignatius Study", also part of the Presidential reorganization effort, has been directed to examine "overlapping and duplication in staffs ... layering of staffs ... and shared responsibilities." For example, the present procedure of having ASD(HA) report to SECDEF through ASD(MRA&L) appears somewhat cumbersome and unique, and may well be reappraised. To date the efforts of the "Ignatius Study" and the "Rice Study" overlap. Their areas of investigation are not mutually constrained. Both studies are looking at potential economies which might result from centralizing resource control at the OSD level. Both with undoubtedly study the Defense Health Care System.

In addition to the foregoing, two other organizations outside Navy also require mention:

The TRIMIS (Tri-Service Medical Information System) also appreciably affects the Navy. The TRIMIS Program Office (TPO), located in the Rockville area, previously worked directly for ASD(HA) and was not responsible to the Defense Health Council. The TPO has recently been transferred to the Defense Logistics Command. This office "coordinates" testing, evaluation, procurement of all automated systems. In actuality it has effectively prohibited any service from unilaterally procuring or developing any medical information system.

Another organization which affects our medical care is the OSD Office of Planning and Policy Analysis (which includes former members of the ASD(H&E) Health Personnel Task Force). The medical segment of this office is best described as the special analysis arm of OSD for health care matters. Its responsibilities include analysis of the implementing actions of the DoD/OMB/HEW Military Health Care Study, mobilization and contingency planning, and variable incentive pay for physicians. It maintains liaison with the Defense Health Council and should be viewed as an influential advisory group to OSD in health affairs. One must consider the inevitably closer working relationship of this OSD office and the DHC. However, it should be noted that OSD recently returned the DHC secretariat personnel back to their respective Services pending review of the functions of OSD(HA).

Finally, there is the complex CHAMPUS system. This is budgeted and administered by OSD; participation by the individual services is nominal. CHAMPUS is an important factor in Navy and Marine active duty morale, and it impinges even more strongly upon the morale of dependents and retirees (whose aggregate numbers dwarf those on active duty). Such potent effect upon morale affects our military readiness.

The CHAMPUS system is both expensive and complicated. Sufficient complaints have been received by all services to indicate that its administration is imperfect. Because of such numerous grass-roots complaints there may be a move afoot in OSD to return this controversial medical matter back to the individual services.

In summary, the practical result of on-going OSD initiatives (simplistically put) is that Navy increasingly cannot unilaterally move any major medical resources --

personnel or equipment. Despite the official POM processes of individual services, it is now more and more impossible -- in reality -- to add major medical resources, delete major medical resources or to change major medical resources without official sanction by OSD(HA). Although de jure responsible for Navy's medical readiness, the CNO and the Surgeon General are de facto simply responding to OSD medical trade-offs which consider mainly a peacetime environment. We must, of course, care for our beneficiary population in the most efficient manner. But above all, we must be prepared for war -- and such preparations can never be cost-effective when balanced against peacetime optimization.

What should be the Navy-Marine posture with respect to current OSD initiatives?

RECOMMENDATIONS:

1. The CNO/VCNO insure concerted Navy input, in the medical area, to the OSD reorganization studies taking place under the guidelines of the Presidential Reorganization Project. Two studies are involved, the Resources Study (Rice Study) and the Defense Department Headquarters Study (Ignatius Study). Particular accent should be placed upon Navy-Marine medical contingency and wartime requirements as well as peacetime training therefor.

2. The CNO support the Defense Health Council concept and the Navy's Surgeon General participation therein. Other mechanisms intended to centralize control over medical matters in OSD would probably have a more adverse affect on the Navy Secretary's and the CNO's ability to do medical contingency planning.

3. The VCNO:

a. Insure constant, active participation by the Surgeon General in deliberations of the Defense Health Council, which appears to be a key OSD entity for control of military health care.

b. Insure awareness of DHC deliberations through both post-meeting discussions with the Surgeon General as well as personal, bi-annual updates for the CNO (along with appropriate DCNOs and DMSOs).

c. Make both formal and informal representation to SECNAV that all DHC recommendations be staffed through the SECDEF/SECNAV command chain prior to any decisions.

4. The Surgeon General:

a. In cooperation with the other Surgeons General, insure the DHC places greater relative stress upon medical readiness and contingency requirements as separate (although related) from peacetime care of the beneficial population.

b. Insure that his staff is organized to support him rapidly and thoroughly in participations of the DHC, especially in the planning and programming areas.

c. Suggest the DHC and OSD(HA) refrain from encouraging or sponsoring further studies until a careful review is made of the multitudinous health care studies by OSD and the individual services during the past decade: determine what has been done, what should still be done, and what is presently impossible.

d. As a member of the OPNAV staff, work closely with OP-01/CHNAVPERS and CMC regarding those matters taken up by the Defense Health Council which affect retention, recruiting and morale of uniformed personnel in the Navy Department.

5. CHINFO, in view of the strong interest by personnel in the Navy and Marine Corps about medical care for themselves and their dependents, mount a more aggressive public relations campaign to explain the "whys" and "wherefores" of present medical-dental care. Particularly the complex CHAMPUS area should be stressed.

PART 6

APPENDICES

A - STUDY TASKING LETTER

B - HEALTH CARE STUDIES COMPENDIUM

C - PROPOSED POA&M FOR CONDUCT OF OP-09E STUDY

D - REQUEST AND APPROVAL OF TIME EXTENSION

E - PROGRAM ELEMENT DESCRIPTION I

F - EXERPTS FROM NWP 12(A) I

G - EXERPTS FROM NWP 11(B) I

H - EXERPTS FROM BUMEDINST 5450.4C II

I - SECDEF MEMO OF 28 DEC 1976 III

J - ASN(M&RA) MEMO OF 15 DEC 1976 III

K - ASD(HA) MEMO OF 30 DEC 1977 III

L - ASD(HA) MEMO OF 28 FEB 1977 III

M - ASN(M&RA) MEMO OF 18 DEC 1977 III